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11-0900-17085-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Sioux Valley Canby Campus Nursing Home
Survey Exit Date: February 16, 2006

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) review conducted by Administrative Law Judge Barbara L. Neilson. By agreement of the parties, the review was conducted based solely on the submission of written documents. All documents were provided by June 6, 2006.

Marci Martinson, Unit Supervisor, Division of Facility and Provider Compliance ("DFPC"), Minnesota Department of Health ("Department"), 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970, appeared on behalf of DFPC.

Susan M. Schaffer, Attorney at Law, Orbovich & Gartner, Chartered, 408 St. Peter Street, Suite 417, St. Paul, MN 55102-1187, represented Sioux Valley Canby Campus Nursing Home.

NOTICE

Under Minn. Stat. § 144A.10, subd.16(d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based upon the exhibits submitted and the arguments made, and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

Findings 1 and 2 set forth in the citation for F 241 are supported by the facts, but the assignment of severity rating "G" is not supported by the facts. The severity should be amended to rating "D" (isolated in scope; no actual harm with potential for more than minimal harm that is not immediate jeopardy).

Dated: June 20, 2006

s/Barbara L. Neilson

BARBARA L. NEILSON
Administrative Law Judge

(Decided on written submissions; no meeting held.)

MEMORANDUM

The Department of Health completed a standard survey of Sioux Valley Canby Campus ("Sioux Valley" or "the Facility") on February 16, 2006. Based on this survey, the Department issued citations for a number of deficiencies. In this IIDR, the Facility is disputing only Findings 1 and 2 with respect to the deficiency cited at F-241.[1] Findings 1 and 2 relate to Residents No. 16 and No. 5, respectively. Sioux Valley requests deletion of these Findings related to call light response and the actual harm determination, and a re-evaluation of the scope and severity score assigned to the remaining findings in F 241. Sioux Valley contends that, upon re-evaluation, findings related to F 241 may constitute no actual harm with potential for minimal harm, which is the lowest severity level score.

The survey process operates under the overall authority of the Centers for Medicaid and Medicare Services ("CMS"). CMS is a division of the U.S. Department of Health and Human Services. CMS holds facilities to a standard of substantial compliance with regulations. "Substantial compliance" is defined as "[a] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm."[2] When citing deficiencies, surveyors use the CMS "Chart of Enforcement Remedies" (commonly referred to as the "Scope and Severity Grid").[3] The level of deficiency and the enforcement action to be taken is set out on each square of this Grid. The scope axis ranges from isolated (level 1), pattern (level 2), or widespread (level 3). The severity axis has four levels ranging from no actual harm with potential for minimal harm (least severe or level 1); no actual harm with potential for more than minimal harm that is not immediate jeopardy (level 2); actual harm that is not immediate jeopardy (level 3); and immediate jeopardy to resident health or safety (most severe or level 4). Each square on the Grid has a letter designation. A is the least serious, and L is the most serious.

Tag F 241

The federal regulation governing resident dignity set forth in 42 C.F.R. § 483.15(a) states that "[t]he facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." The Guidance to Surveyors defines "dignity" to mean that, in their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth.

In its Statement of Deficiencies, the DFPC alleges that this requirement was not met by Sioux Valley in part because it determined that "the facility failed to treat residents in a dignified manner by not responding to call lights in a timely manner for 2 of 17 (#5 and #16) residents in the sample who had a history of incontinence and needed staff

[1] The Facility has withdrawn its request for review of F-322 that was issued on the standard survey and re-issued on the revisit survey.
[2] 42 C.F.R. 488.301
[3] Ex. B-4.

assistance for toileting . . . ."[4] The DFPC made two other findings in connection with this deficiency that are not at issue in this IIDR, and ultimately assigned a scope and severity level of "G," meaning that the deficiency was found to be isolated in scope but resulted in actual harm that was not immediate jeopardy.

The survey findings at issue in this IIDR were based on interviews with Residents 5 and 16 and a member of Resident 5's family. At the time of the survey, Resident 16 was a 94-year-old woman whose diagnoses include Parkinson's Disease, paralysis agitans (tremors), and hypertension.[5] Resident 16's Minimum Data Set dated October 3, 2005, revealed that the Resident had no cognitive impairments, did not have socially inappropriate behaviors, and was occasionally incontinent.[6] Nurses' Progress Notes dated January 30, 2006, indicated that Resident 16 was alert, her short-term and long-term memory was okay, she was oriented to time, place, and person, she was able to make independent decisions, she was frequently incontinent of bladder, and she required extensive assistance with personal hygiene/toilet use.[7] From January 15 to January 18, 2006, Resident 16 was hospitalized in the hospital adjoining the Facility for cough and fever, pneumonia, acute bronchitis and dehydration. During hospitalization, Resident 16 received IV fluids for rehydration. Hospital records indicate that she had stress incontinence with her cough. She also experienced some episodes in which her incontinent product, bedding, and clothing were saturated.[8]

During her first interview with surveyors on February 13, 2006, Resident 16 stated that her call light had not been answered for 30 minutes "lately," and was not answered at all on another recent occasion. The Resident stated that she was wet on both occasions. During her second interview on February 16, 2006, Resident 16 stated that she had turned her call light on this month during the night shift, but Facility staff did not come for 30 minutes and she was wet because of the long wait for help. She indicated that a second episode also occurred within the past month during the night shift. On the second occasion, she said she waited so long that she just fell asleep and was wet again because she did not get any help. She told the surveyors that she did not want to call for help because it was after 11:00 p.m. and she did not want to wake up other residents. The Resident told the surveyors that the two incidents made her mad because she had an accident in her brief, and she was upset about the length of time it took to answer the call light. The surveyor noted that the Resident's voice was loud and her face was pale as she related this information.[9]

Resident 5 is a 94-year-old woman whose diagnoses include hypertension, osteoarthritis, diabetes, osteoporosis, and depression. Her Minimum Data Set dated January 17, 2006, indicates that she has no memory problems or behavioral symptoms, has mild cognitive impairment in daily decision-making (some difficulty in new situations

[4] Form CMS-2567 at 6.
[5] Ex. F-1a.
[6] Ex. F-8 and F-9.
[7] Ex. 3 at 295.
[8] Ex. 3 at 297, 300-02, 306.
[9] Ex. F-2b, F-5b.

only), requires extensive assistance with toilet use, and is occasionally incontinent.[10] Her current care plan dated December 8, 2005, stated that she was "incontinent at times during the day and [night], at times usually if she waits too long" and noted that she usually "rings for help."[11] Resident 5 complained to a surveyor during her interview on February 15, 2006,[12] that she had waited for staff to respond to her call light for up to 30 minutes within the last month. She said that she had reported the slow response time to facility staff. She was not incontinent as a result of the wait.[13] During a telephone interview with Resident 5's family member, the family member reported that Resident 5 had complained to the family about the slow response to call lights and said that she had waited up to 30 minutes for staff response.[14]

Sioux Valley asserts that it treats its residents in a dignified manner and responds to their call lights in a timely manner. The Facility contends that the complaints of Residents 5 and 16 are not credible evidence of deficient practice in violation of F 241, and requests that those findings be deleted because it was in substantial compliance with the federal regulation. The Facility argues that the survey findings do not include any observations to substantiate the residents' complaints that staff do not respond promptly to resident call lights, and argues that the two resident complaints alone should not constitute sufficient evidence of a deficient practice.

The Facility has a call light system that monitors and tracks response time after call light activation. It offered to provide this information to the survey team on February 17, 2006,[15] and provided computer print-outs in connection with this IIDR indicating the call light activation and response times for Residents 16 and 5 during the month preceding the survey.[16] Sioux Valley contends that this information shows that call lights for Resident 16 and Resident 5 were answered in 20 minutes or less during the month prior to the survey. The Facility also points out that Resident 16's call light was activated 153 times in the 31 days prior to the survey and she was hospitalized three of those days, and asserts that her allegations of two instances of delayed response to call lights do not amount to deficient practice on the Facility's part. With respect to Resident 5, the Facility indicates that the call light information shows that Resident 5's call light was activated 185 times between January 13, 2006, and February 13, 2006, and contends that one alleged instance of waiting up to 30 minutes does not constitute deficient practice.

Sioux Valley's Director of Nursing, Laurie Stee, R.N., noted in a written declaration provided in connection with the IIDR that night shift staff would answer call lights at the nursing station desk control panel instead of in the resident's room because they wanted to avoid having the audible bell signal disturb sleeping residents. They typically

[10] Ex. G-9 through G-11.
[11] Ex. G-17.
[12] The DFPC points out that the surveyor's notes indicate the interview occurred on February 15, 2006, but the CMS 2567 erroneously identifies this interview as occurring on February 14, 2006.
[13] Ex. G-6a.
[14] Ex. G-8a.
[15] Ex. 4.
[16] Exs. 5A, 5B.

responded to the resident's room after answering the call light at the desk. Some shorter staff were not able to reach across the resident's bed and cancel call lights, so they returned to the desk to cancel the call light.[17] In Ms. Stee's experience, residents sometimes put on their call lights and then fall back to sleep before staff respond. In such instances, staff generally do not wake up the resident to ask why the call light is on. She believes that Resident 16 was acutely ill and weak during January and early February of 2006, and it is possible that she could have put her light on for assistance to the bathroom and fallen asleep within minutes.[18]

Sioux Valley also argued that the deficiency was undermined by the fact that Resident 16 reported that Facility staff had "gotten better" after she reported the situation to a nurse,[19] and the surveyor who completed the Resident Daily Life Review portion of the Resident Review Worksheet for Resident 16 indicated that there were no identified concerns for the Resident with respect to the daily life review (which includes staff being responsive to resident requests and call bells).[20] The Facility also asserts that Resident 16's recollection of a delayed call light response and a saturated incontinent product are more likely than not related to her hospitalization rather than her nursing home stay. The Facility points out that hospital records showed that, on the first two nights of hospitalization, Resident 16 had a diaphoretic incident requiring a bedding change and a saturated incontinent product. Because the hospital is located right next to the Facility, residents who are being hospitalized usually do not leave the campus or have to go outdoors or be transported by ambulance. Nursing home staff visits residents often when they are in the hospital since the hospital is right next to the employee cafeteria.[21]

In response to the Facility's initial filing during the IIDR, the DFPC argued that information provided by other residents also substantiated the concerns of Resident 16 and 5 that a deficient practice existed. In this regard, the DFPC emphasized that the survey team received similar complaints regarding call light response from another resident (Resident 15) and during a group interview. Resident 15's minimum data sheet indicates that Resident 15 had no cognitive impairments or behavior concerns, was occasionally incontinent, and required extensive assistance with many activities of daily living.[22] Resident 15 told the surveyors during an individual interview on February 16, 2006, that Facility staff would turn off the light and say that they would be back, but would not return.[23] During a group interview on February 15, 2006, an unidentified person said that staff turns off the call lights, and there were "call lites [sic] up to 30 minutes."[24] Although the surveyors did not observe any problem with timely response to call lights during the survey period, the DFPC contended that it is rare that poor call light response is noted during a survey because facility staff are aware that surveyors are observing.

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[17] Ex. 5 at ¶¶ 8-9.
[18] Ex. 5 at ¶ 10.
[19] Ex. F-2b.
[20] Ex. F-1a.
[21] Ex. 4.
[22] Exs. H-7, H-8.
[23] Ex. H-5.
[24] Ex. H-2a.

The DFPC also emphasized that the Principles of Documentation (a federal document that outlines the standards for documenting citations) indicates that, to the greatest extent possible, the surveyor should verify the information obtained from interview through observation or record review. In the absence of other objective validation of information, multiple interview sources may be used to verify information.[25] In addition, Appendix P directs surveyors to collect Quality of Life information through individual, group, and family interviews as well as through observation of staff interactions,[26] and the State Operations Manual acknowledges that sometimes other sources will not corroborate information provided in interviews. In such instances, the Manual indicates that the team will need to determine during the process of decision making whether the interviewees are reliable sources of information, if the information is accurate, and if a deficiency occurred. The Manual states that "citation of a deficiency may be based on resident information alone."[27]

In its reply brief, Sioux Valley emphasized that the information from the group interview and Resident 15 was not cited in the Statement of Deficiencies as support for the deficiency and questioned whether the information was not included because the surveyors did not find the information credible. Sioux Valley also correctly pointed out that the notes from the group interview and the interview with Resident 15 are sparse on the call light issue. In particular, the group interview notes do not indicate when the delay occurred, how often, or how many residents in the group voiced this concern, and the notes from the interview with Resident 15 do not indicate when or how often Resident 15 asserted the problem occurred.

Based upon a review of all of the evidence presented in this case, the Administrative Law Judge finds that the citation is supported. There is no evidence in the records of Residents 16 or 5 suggesting that they would not be reliable historians or that they had a tendency to make false allegations. In fact, it appears from the Facility records that no memory problems or behavioral symptoms have been noted with respect to either of these residents. Despite the fact that the hospital adjoins the nursing home, there is no indication in Resident 16's hospital records that her call light was not answered promptly in the hospital or that the Resident confused her hospital care with her nursing home care. Even if staff chose not to disturb Resident 16 on the second occasion because she had fallen asleep, it is still clear that Resident 16 reported that she had waited a long time and then fell asleep. The fact that Resident 16 reported the same information to surveyors on two separate occasions and the fact that Resident 5 also told a family member that she had waited up to 30 minutes for a staff response to her call light increases the likelihood that their statements are accurate. Although the surveyors' notes from the group interview and Resident 15's interview are sketchy and references to those sources were not incorporated in the Statement of Deficiencies, the complaints are similar in nature and provide further support for the DFPC's overall conclusion that there were delays in call light responses in the Facility and that those delays were an affront to resident dignity.

[25] Ex. C-1.
[26] Ex. B-5.
[27] Exs. B-7, B-10.

While the Facility argues that the call light information does not show any response times of 30 minutes or more for Residents 16 or 5, it is evident that the call light information does not necessarily show actual response time. The call light could have been de-activated from the nurse's desk, and could have been de-activated before care was actually provided to the resident (as suggested by Resident 15 and the group interview participant). The call light computer printouts simply do not show whether or not care was always provided in a timely manner after it was requested. The fact that the call light information shows thatResident 5 experienced a 21-minute wait for a response to a call light on February 9, 2006, also lends some support to the allegation that delays were, in fact, a problem.

The other arguments made by the Facility also are not convincing. For example, the mere fact that the surveyor initialed the first page of the Resident Review Worksheet and the team did not identify concerns relating to Resident 5 in their draft survey findings does not contradict the team's specific findings of a deficiency based on Residents 16 and 5 and the detailed information included on the Form 2567. The mere fact that Resident 16 said the situation was "better" after she reported her concerns to a nurse does not necessarily mean that her concerns about slow call light response no longer existed. Finally, the generally positive evaluation of the Facility provided by Resident 5's family member and the Resident's indication that she got all the help she needed from staff in the form of assistance with standing, walking and dressing do not call into question the legitimacy of her complaints about delayed call light response.

The Administrative Law Judge thus finds that Findings 1 and 2 of the citation are supported.

Severity Level - Actual Harm

As a threshold matter, the DFPC contends that, in accordance with CMS guidance, the scope and severity of this deficiency cannot be disputed in this IIDR because it does not involve substandard quality of care or immediate jeopardy. In response, Sioux Valley asserts that both the state statute and federal regulations permit nursing homes to dispute survey findings, and contends that the Administrative Law Judge is permitted to consider whether the scope and severity should be reduced. If a deficiency is found, the Facility agrees that it is properly considered to be isolated in scope, but urges that the severity assigned to the deficiency be reduced from Level 3 (actual harm) to Level 1 (no actual harm with potential for minimal harm), resulting in an overall rating of "A".

Minn. Stat. § 144A.10, subd. 16(d)(5), specifically authorizes determinations issued in connection with IIDR proceedings to include a finding that a citation's "[s]everity [is] not supported," and permits a recommendation to be made that a citation be "amended through a change in the severity assigned to the citation." There is no language in the statute limiting such situations only to IJ or substandard quality of care severity levels. In addition, the federal regulations set forth in 42 C.F.R. § 488.331(a) require states to offer facilities an informal opportunity "to dispute survey findings." Thus,

notwithstanding CMS's informal policy statements to the contrary in the State Operations Manual and Program Letter instructions, it appears that the DFPC's determination that Resident 16 suffered actual harm is a "survey finding" that may be disputed by the Facility in this IIDR.

In support of the assignment of a severity level of 3 (actual harm), the DFPC contends that the fact that Resident 16 continued to display emotion in expressing her complaint by stating she was mad and upset and raising the volume of her voice reflects that the lack of timely assistance resulting in incontinence caused her to sustain actual emotional harm. DFPC relies solely upon Resident 16's demeanor and verbal presentation as evidence of actual emotional harm. Sioux Valley contends that the DFPC has not demonstrated that Resident 16 sustained actual harm and argues that complaints by Residents 16 and 5 of three untimely call light responses during the month prior to the survey should be determined to pose no greater risk to resident health or safety than the potential for causing minimal harm. The Facility asserts that, if anything, the delayed call light response could or has caused limited consequences to Resident 16, particularly since she used the past tense while describing her feelings about the incident. With respect to the second incident involving Resident 16, the Facility points out that information is lacking concerning whether Resident 16 had her accident before or after she fell asleep, or how long she waited for a response to the call light before falling asleep.

Appendix P of the State Operations Manual provides guidance to surveyors in making deficiency determinations. According to the Manual, a finding of severity Level 3 ("actual harm") such as was made here requires a finding of "noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident."[28]

The record in this case does not reflect any link between the delayed call light response on two occasions and any negative outcome that compromised the Resident's physical, mental, or psychosocial well-being. Even if Resident 16 became mad and upset when there was a delay in responding to her call light, and even if she experienced episodes of incontinence by virtue of the delay, the mere experiencing of such feelings or the mere occurrence of incontinence does not show that she experienced actual emotional or physical harm. As noted by the Facility, it did not appear from the interview notes that she continued to feel mad or upset by the time of the survey because she used the past tense in describing her feelings. And little conclusion can be drawn from the fact that her face seemed pale, since she was interviewed during the winter just weeks after she was hospitalized for pneumonia and bronchitis. The more positive fact that the Resident believed that the call light situation had gotten better after she complained to a nurse must also be taken into consideration in evaluating her emotional state.

[28] State Operations Manual, Appendix P-72.

Overall, there is no convincing basis to conclude that Resident 16 sustained anything other than a limited consequence as a result of the two delayed staff responses. Although the deficiency resulted in a loss of dignity for the Resident and she was angry and upset about not receiving timely assistance, the Judge does not find the situation to be analogous to the SOM example cited by the DFPC of potential or actual physical, mental, or psychological injury caused by the "[l]oss of dignity due to lying in a urine-saturated bed for prolonged period."[29]

The survey findings do not indicate that Resident 5 sustained any actual harm related to delayed call light response. In fact, the findings show that Resident 5 was not incontinent as a result of the delayed call light response. Because there is no identified actual harm or negative outcome related to Resident 5, the findings related to Resident 5 should not be used to sustain a determination of actual harm.

On this record, the Administrative Law Judge concludes that a severity rating of "D" is appropriate since the deficiency resulted in no more than minimal physical, mental and/or psychosocial discomfort to Resident 16 and had the potential to compromise her ability to maintain her highest practical level of well-being. The Judge thus recommends that the citation be amended to reflect a severity rating of "D."

B.L.N.

[29] Ex. B-9.